

Tufts Medical Center testimony
RE: *Proposed regulation 958 CMR 8.00*
Registered Nurse-to-Patient Ratio in Intensive Care Units in Acute Hospitals
April 13, 2015

Tufts Medical Center would like to thank the Health Policy Commission (HPC) for the opportunity to provide comment relative to the proposed regulation 958 CMR 8.00, Registered Nurse-to-Patient Ratio in Intensive Care Units in Acute Hospitals.

Tufts Medical Center's clinical care teams provide complex care to thousands of patients each year, across several different types of critical care units and we are proud to report among the highest quality and outcome measures. It is our firm belief that, as written, MGL c.155 provides an acceptable and workable framework for nursing assignment within intensive care units and caution should be taken in unnecessarily altering or going beyond the intent of the law. Tufts Medical Center would like to raise the following concerns with the proposed regulation, to which more specific recommendations are provided below:

- ICUs should be allowed to operate with maximum flexibility, which will be made impossible by the "at all times/at any time" language in the proposed regulation.
- The regulation should apply to critical care patients within an ICU. We ask the commission to include in its definition of an ICU patient the language from the definition in 105 CMR 130.020 of an ICU, which refers to the patients therein.
- The Acuity Tool should be utilized only as an advisory tool to supplement the clinical decision making of the care team.
- Adoption of the acuity tool should be phased-in across the various intensive care units, in a manner consistent with the implementation of other technologies utilized the hospital setting.

Maintain maximum flexibility for optimal patient care

The ability to function as a dynamic team with open lines of collaboration, communication and action is critical to the success of the care team in an ICU. Anything that constrains the flexibility and nimbleness of the care team to attend to the rapidly evolving needs of ICU patients has the potential to negatively impact patient outcomes. Our ICUs have operated for decades with multidisciplinary teams making appropriate care decisions, establishing clinical protocols and delivering excellent patient care. These results from the ICUs are a matter of careful planning, teamwork and the constant pursuit of excellence in patient care.

The delivery of care in ICUs and care protocols evolves rapidly; this pace and the resulting outcomes are heightened by the considerable research conducted each year on the most effective methods of care. Much of this research has been conducted with the participation and leadership of critical care nurses and results in saving lives once thought impossible. Tufts Medical Center has created numerous dashboards to capture and analyze metrics, implemented quality improvement projects, written publications and received awards as a direct result of our teamwork and relentless focus on patient outcomes.

Tufts Medical Center understands the impact of excellence in nursing care within the critical care community. The delivery of excellent nursing care is complicated; it is not just about the number of patients or number of providers. The ICU is a place that cannot be served by a simple equation, **an assignment of 1 RN to 1 patient or 1 RN to 2 patients cannot be misunderstood as a ratio of 1:1 or 1:2 at all times during the a shift and at any time during a shift**, as it is currently proposed. Establishing a patient assignment at the start of a shift is standard practice, however, regulating a focus on numbers for every minute and throughout the entirety of a shift will significantly alter the innately supportive dynamic and culture of collaboration that is the foundation of care delivery in the ICU.

The current reporting of staffing metrics in ICUs may not accurately depict the rapid patient changes, nor the corresponding staffing changes that occur in critical care units like the Cardiothoracic ICU (CTU); and as written the proposed regulation would not allow for the appropriate allocation of resources in such units. The CTU is a prime example of the complex and dynamic environment of an ICU. The workload of the CTU at Tufts Medical Center is driven by the surgery schedule, where surgeries are predominantly performed Monday through Thursday; Friday through Saturday finds this unit much quieter with a lower patient census and caring for less complex patients than during the weekdays. Another important factor which dictates the fluctuation in care resources throughout this unit is the extremely rapid recovery time. Due to advances in cardiac surgery and post-surgery care protocols, a patient undergoing a heart procedure in the morning may be discharged home within 24-48 hours. This evolution in patient care has changed the manner in which we provide care to cardiac patients on this unit and therefore dictates a constantly evolving staffing scenario.

The critical care environments most conducive to the best patient outcomes are those that can be fluid, flexible, and responsive to the needs of patients, families and providers. Nurses within an ICU do not ever take care of just their own 1 or 2 patient assignments. They work together as a nursing team, providing consultation to their colleagues, assisting, encouraging, supporting, mentoring and learning with and from each other. In an ICU the patients' needs change constantly. Nurses need to be responsive and should not be placed in a position of conflict between what is right for the patient and the care team dynamic and what the regulation states. All shift long, nurse leaders/managers are proactively planning for the "what if" situation. During such cases nurse leaders and managers work together to fully understand and create a new plan to ensure **all patients** in the unit are cared for in a way that will achieve the best patient outcomes. Urgent and emergent patient situations arise which require the ability to allocate staff fluidly throughout the ICU, such as Central Line Placement, Urgent Head CT/MRI, Family meetings, Withdrawal of Care support to a family or colleague, a new diagnosis disclosure, bedside clinical assistance or consultation, turning and positioning or Medication co-signing. Establishing an overarching regulation that puts the focus on numbers and the consequential rigidity in the allocation of care personnel will directly impact patient care delivery which will result in delaying patients' access to care by creating a focus on the number of nurses versus the needs of patients.

Focus on the critically ill patients within the ICU

Tufts Medical Center asks the HPC give strong consideration to ensuring that the definition of ICU Patient in the regulation reflect the referenced regulation 105 CMR 130.020 of an ICU, which **refers to the critically ill patients within the unit**. ICU patients who gain stability and demonstrate readiness to transfer to a medical/surgical unit may be held in the ICU, even though they no longer require an intense level of critical care. This may happen because other patients in the hospital, such as those waiting in the Emergency Department, must receive priority placement in the immediately available medical/surgical beds. Ensuring this regulation applies appropriately to critically ill patients within an

ICU will accurately reflect the regulation referenced in Chapter 155 and deliver on its goal of enhancing patient safety.

Acuity tool implementation and utilization

Tufts Medical Center asks the HPC to give strong consideration to allowing providers more flexibility in the selection and implementation of an acuity tool. Any acuity tool will not be completely accurate and will lack an ability to provide an overview of the ICU as a comprehensive unit. An evidence-based acuity tool does not yet exist that can reliably predict the needs of a patient and the nursing time that will be necessary. The assessment and needs calculation of both the individual patients and the unit as a whole is performed constantly by nursing leadership, staff nurses and other care team members. For this reason it is critical that the acuity tool be designated the appropriate amount of reliance, and **utilized only as an advisory tool**, that is not intended to supplant the clinical judgment of caregivers. We ask the HPC to ensure this is the case as they consider the precise language that will dictate the use of the acuity tool.

Tufts Medical Center Recommendations:

- **Maintain maximum flexibility within ICUs/ Removal of “at all times/at any time”**

Consider revising Section 8.04 as follows:

(1) In all ICUs, the Patient Nursing Assignment of any ICU patient for each Staff Nurse shall be one or two ICU Patients at all times during a Shift.

(2) Consider striking this section because it is redundant.

The maximum Patient Assignment for each Staff Nurse may not exceed two ICU Patients at any time during a Shift.

- **Acuity tool implementation and utilization**

Consider revising 8.05 as follows:

(1) For purposes of determining a Patient Assignment, the Staff Nurse assigned to care for the ICU Patient, together with the other members of the care team, the charge RN and the nurse Manager or Nurse Supervisor assigned to care for the ICU Patient shall assess the stability of the ICU Patient utilizing:

(a) A collaborative approach.

Or

In combination with other variables* A ~~decision~~-support tool using a method for assessing patient stability for the ICU Patient according to a defined set of indicators, and used in ~~the determination guiding the decisions for~~ of a Patient Assignments.

*Other variables:

the experience of the RN,

the experience of other RNs on the team,

availability of support staff

needs of other patients within the care area

availability of MD support

and other conditions within the environment will also be taken into consideration when creating patient assignments.

8.05 (2)

In combination with other variables* A ~~decision~~ support tool using a method for assessing patient stability for the ICU Patient according to a defined set of indicators, and used in ~~the determination guiding the decisions for of a~~ Patient Assignments.

*Other variables:

the experience of the RN,

the experience of other RNs on the team,

availability of support staff

needs of other patients within the care area

availability of MD support and other conditions within the environment will also be taken into consideration when creating patient assignments.

8.05(3) a,b,c

The Staff Nurse assigned to care for the ICU Patient shall assess the stability of the ICU Patient continuously to ensure the plan for nursing care is complete and adequate to meet the current and predicted needs of the patient.~~using the Acuity Tool at a minimum:~~

~~Upon the ICU Patient's admission or transfer to the ICU;~~

~~Once during a Shift; and~~

~~At other intervals or circumstances as specified in the Acute Hospital's policies and procedures established pursuant to 958 CMR 8.07(6).~~

8.06 2b subsection (3)(4) I,ii,iii,iv

How results and scores are tabulated and used to guide in the decision of the allocation of nursing services. ~~determination of whether each ICU Patient requires care by one or more Staff Nurses, or by a Staff Nurse assigned to care for no more than two ICU Patients; and~~

~~Critical environmental factors relevant to the particular ICU and that may affect the ability of Staff Nurses to care for one or two ICU Patients that should be addressed in the selection or development of the Acuity Tool, such as:~~

~~Physical environment of the unit, including visibility of patient/monitoring equipment;~~

~~Nursing skill mix, competency and familiarity with the ICU;~~

~~Availability of patient care equipment and technology; and~~

~~Availability of ancillary and support staff in the ICU (e.g., pharmacist, IV team/respiratory therapist, nurse practitioner, clinical nurse specialist, physician assistant, unit secretary, sitters, aides/technicians, staff to operate patient care equipment and technology, patient transport services, travel team/coverage);~~

8.06 (3)

Consider striking this section in its entirety as it is not required in Chapter 155.

~~Nothing in 958 CMR 8.06 shall restrict or limit any additional obligation of an Acute Hospital to bargain with a labor organization under applicable law, regulation or collective bargaining agreement~~